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	085047	A. BUILDING _____ B. WING _____	03/07/2017

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GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

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F 000	INITIAL COMMENTS An unannounced annual recertification survey was conducted at this facility from February 27, 2017 through March 7, 2017. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 105. The Stage 2 survey sample size was 24. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; BM (bm) - bowel movement; CNA - Certified Nurse's Aide; Cognitive Impairment - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Continence- ability to prevent accidental leakage of urine from bladder; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; DES - Director of Environmental Services; DMM - District Maintenance Manager; DON - Director of Nursing; eMAR - electronic Medication Administration Record; EMR - Electronic Medical Record; Frequently Incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period; Humalog Insulin - fast-acting insulin that keeps sugar levels in balance; Incontinence - loss of bladder control;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/28/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

Insulin - a hormone that lowers the level of glucose (a type of sugar) in the blood by helping glucose enter the body's cells. Doctors use this hormone to treat diabetes when the body can't make enough insulin on its own;
Involuntary Seclusion - separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will;
LPN - Licensed Practical Nurse;
MDS/Minimum Data Set - standardized assessment forms used in nursing homes;
Mixed (urinary) incontinence - combination of stress and urge incontinence, it shares symptoms of both;
ML (ml) - milliliters, a unit of liquid volume or capacity in the metric system, 5 ml equals 1 teaspoon;
MOM- Milk of Magnesia, a laxative used to stimulate bowel movements;
Morse Fall Scale - standardized assessment tool used to identify resident's risk for falling;
NHA - Nursing Home Administrator;
Novolog Insulin - a rapid-acting insulin used to lower blood sugar/glucose;
Occasional Incontinence- less than 7 episodes of urinary incontinence in 7 day look back period;
Paralysis - loss of voluntary movement;
Peri-area - area between the thighs, the external genitals and anus
RN - Registered Nurse;
RNAC - Registered Nurse Assessment Coordinator;
Sliding scale with insulin coverage - A dosing schedule that is based on a particular blood sugar value or range of values. The insulin dose to be administered becomes greater when blood sugar readings are higher. Each sliding scale needs to be tailored to the individual, as each patient has

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F 000	Continued From page 2 unique circumstances and different insulin requirements; Stand Up Lift- used to transfer residents from one seating surface to another; requires resident to have some weight bearing capability; Stress incontinence - occurs when bladder leaks urine during physical activity or exertion; Supervision - oversight, encouragement or cueing; Units - measurement used in the administration of insulin; Urge incontinence- loss of urine with an abrupt and strong desire to urinate; usually loss of urine en route to toilet; UTI/Urinary Tract Infection - bacteria in the urine; Void - to urinate; Voiding Diary - a record of voiding (urinating) for 72 hours and/or 3 days; Wanderguard - electronic bracelet worn on arm or leg that causes an exit to alarm when approached by person wearing the bracelet.	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at	F 164		4/21/17

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F 164	Continued From page 3 §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide personal privacy for 1 (R3) out of 24 Stage 2 sampled residents. R3's privacy was not maintained when the computer on top of the medication cart containing the resident's MAR and personal information was unlocked and visible to anyone walking by the medication cart. There was no facility staff in sight when R3's information was observed. Findings include:	F 164	1. Laptop information was secured upon discovery for R3. 2. All residents may be affected, however during this observation no other residents were affected, as there were no unauthorized people in the area. 3. All nursing staff will be in-serviced regarding privacy and protection of protected health information(PHI). Reminders will also be added on devices	

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F 164	Continued From page 4 On 2/27/17 at 12:30 PM, a medication cart just outside of R3's room was observed and the computer on top of the cart had R3's MAR and personal information visible to anyone walking by. There was no facility staff in view. Findings were reviewed with E14 (RN) on 2/28/17 at 10:15 AM. E14 stated, "I'm sorry, I must have been distracted by something." Findings were reviewed with E2 (DON) on 3/7/17 at 10:30 AM. E2 stated that she also saw a residents MAR visible on the computer on top of the medication cart with no visible staff in view and she spoke to E14 about it.	F 164	to hit the privacy icon before leaving an electronic device unattended. 4. Staff Development Director or designee will observe staff for compliance of closing electronic devices during rounds 3 times per day until 3 days are found to be compliant. Thereafter, Staff Development Director or designee will observe staff daily until 3 consecutive days are found to be compliant. Finally Staff Development Director or designee will observe staff for closing of electronic devices during rounds weekly until 3 consecutive weeks are found to be compliant. Results of this monitoring will be reported to the QAPI Team.	
F 223 SS=D	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview and review of records from the facility and the State of Delaware's Division of Long Term Care Residents Protection (DLTCRP), it was determined that for	F 223	1. Resident R42 was not harmed. E13 was immediately counseled and suspended and received additional training at the time of the incident, prior to	4/21/17

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F 223	Continued From page 5 one (R42) out of 24 Stage 2 sampled residents, the facility failed to ensure that R42 was free from abuse, which included involuntary seclusion. At approximately 3 AM on 6/8/16, E13 (CNA) placed R42 in her bedroom to keep her from wandering into other resident's rooms, closed the bedroom door, placed a chair in front of the bedroom door and sat on the chair to prevent R42 from exiting her bedroom. Findings include: Review of R42's clinical record revealed: 1/3/12 - R42 was admitted to the facility with a primary diagnosis of dementia. 3/11/16 - The quarterly MDS assessment stated that R42 was severely impaired for daily decision making, walked independently and wandered almost daily. The facility's incident report and investigation revealed the following: 6/8/16 at 4:10 PM - The incident description stated, "...E13 (CNA) stated that the resident (R42) had been wandering in and out of several rooms. Despite interventions, R42 continued to wander...E13 initially stated she put R42 in her own room, shut the door and placed a chair in front of the door to prevent her from getting out. When asked what the resident did during this time, E13 said that the resident moved the door handle to try to get out. E13 later changed the story to say the door was partially open. E13 demonstrated the action and showed a partially opened door (only a few inches) with a chair placed in front of it, preventing it from opening further." The facility immediately suspended E13 pending investigation and inserviced all staff.	F 223	the survey. 2. All residents who wander are at risk. RNAC or designee will review care plans for all residents identified with behaviors for wandering. 3. Facility requested and received additional abuse prevention training from the DLTCRP and several in person classes were offered to all staff at Gilpin Hall. Involuntary seclusion will also be more rigorously highlighted during employee orientation. A Safety Competency procedure will be created and shared with all Nursing Staff. (attachment #1) 4. Staff Development Director or designee will conduct a safety competency on 3 staff members per day until 3 consecutive competencies are found to be 100% compliant. Thereafter, Staff development Director or designee will conduct 3 safety competencies per week until 3 consecutive weeks are 100% compliant. Finally, Staff Development Director or designee will conduct a safety competency on 3 staff members monthly until 3 consecutive months are 100% compliant. Results of the competencies will be reported to the QAPI team.	

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F 223	Continued From page 6 6/9/16 and untimed - E3's (ADON) note stated when she questioned E13 why she did not complete a task for another resident during the night shift on 6/8/16, E13 stated that she had a "difficult night." E13 stated, "I put R42 in her room closed the door to her room and I put a chair in front of her door and I sat on the chair." When asked if she reported this to the nurse, E13 stated, "No I did not." When E13 was asked if she called the nurse or supervisor for extra help when she was having difficulty redirecting R42, E13 stated, "No I did not ask for help from nurse or supervisor." 6/10/16 and untimed - E15 (LPN) attempted to interview R42 but she was not able to answer any questions regarding the incident. Emotional support was provided to R42. 6/13/16 and untimed - A summary note stated that E13 confessed and was apologetic. E13 stated that she tried to prevent R42 from wandering into other resident's rooms and waking the residents. 6/14/16 - The DLTCRP's investigation verified the 6/8/16 incident by interviewing E13, in which she confessed. 6/17/16 through 3/6/17 - Review of R42's clinical record revealed no further incidents. 3/6/17 at 1:14 PM - During an interview, E2 (DON) confirmed the finding of abuse. E2 believed that E13 was remorseful for the incident and required her to have one-to-one inservice training before she would be allowed to return to work. E2 stated that E13's employment at the facility ended on 9/7/16 for an unrelated reason.	F 223		

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F 223	Continued From page 7 3/7/17 at 1:15 PM - Finding was reviewed during the exit conference with E1 (NHA) and E2. The facility failed to ensure that R42 was free from abuse, which included involuntary seclusion, on 6/8/16.	F 223		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that for one (R74) out of 24 Stage 2 sampled residents, the facility failed to treat and care for her in a manner and in an environment that promotes the quality of life recognizing each resident's individuality. For R74, the facility failed to serve and assist her with eating at the same time as R7, R51 and R88, all of whom were independently eating lunch at the same table in the 3rd floor dining room. Findings include: 2/27/17 - An observation of the lunch service in the 3rd floor dining room revealed R74 sitting at the table with 3 other residents (R7, R51 and R88). At 12:26 PM, R7, R51 and R88 were eating their meals while R74 watched them. R74, a resident who needed the assistance of one staff person, was served her meal at 12:35 PM. At 12:44 PM, a CNA sat down next to R74 and assisted her with her meal when R7, R51 and R88 were nearly done eating their meals.	F 241	1. Dietary and Nursing staff will be in serviced by Staff Development Director or designee to provide meals to all residents at a table at the same time. R74 received her meal and has no recollection of this meal, but been provided emotional support. 2. All residents who eat in the dining room may be affected. 3. All staff that serves food to residents will be in serviced by Staff Development Director or designee to provide meals to all residents at a table at the same time. A Dining Observation Tool (attachment #2) will be utilized by supervisory staff during meals to ensure that staff provide meals to all residents at a table at the same time. 4. Dining Observation Tool forms will be reviewed by DON or designee until 3 consecutive days show 100% compliance.	4/21/17

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F 241	Continued From page 8 3/2/17 - At 12:25 PM, a second observation of the lunch service in the 3rd floor dining room revealed that R7, R51 and R88 were eating their meals at the same table while R74 watched. R74 was served and assisted with her meal at 12:33 PM when R7, R51 and R88 were nearly done eating their meals. 3/2/16 at 12:34 PM, E9 (LPN) confirmed the second observation finding. 3/7/16 at 10:18 AM, findings were reviewed with E2 (DON). The facility failed to treat and care for R74 in a manner and in an environment that promotes the quality of life recognizing each resident's individuality.	F 241	After 3 consecutive days of compliance, DON or designee will review the dining observation tool weekly until 3 consecutive weeks show 100% compliance. After 3 consecutive weeks of 100% compliance, the monitoring will conclude and results of the monitoring will be reported to the QAPI team.	
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined that the facility failed to provide housekeeping and maintenance services for 3 (219, 247, and 355) out of 37 rooms. Findings include: The following was observed on 3/1/17 from 11:00 AM to 11:45 AM during the Stage 2 environmental tour: Room 219 - The bathroom ceiling tile was water stained;	F 253	1. Ceiling tile was replaced, patched area beside bed was painted, vent has been cleaned, dresser drawers have been repaired prior to the completion of the survey. 2. All resident may be affected. 3. Housekeeping and maintenance staff will be in-serviced by Environmental Services Director or designee on referenced findings and instructed to report like observations immediately. Facility Manager or designee will inspect rooms using the Resident Observation	4/21/17

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F 253	Continued From page 9 Room 247 - A patched area on the wall beside the bed was unpainted; - The vent behind the head of the bed was very dusty; Room 355 - Three dresser drawers were broken or in disrepair. Findings were reviewed with E10 (DMM) and E11 (DES) on 3/1/17 at approximately 11:45 AM. Findings were reviewed with E1 (NHA) and E2 (DON) on 3/7/17 at approximately 1:15 PM.	F 253	tool in Abaqis software (attachment #3). A minimum of 10 room observations will be conducted monthly by Facility Manager or designee. 4. Facility Manager or designee will inspect 3 rooms per day using Abaqis Resident Observation form until 3 consecutive days are 100% compliant. Thereafter Facility Manager or designee will inspect 3 rooms per week until 3 weeks are 100% compliant. Results will reported to the QAPI team.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278		4/21/17

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F 278	Continued From page 10 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R48) out of 24 Stage 2 sampled residents, the facility failed to accurately reflect R48's urinary incontinence status on the 12/23/16 quarterly MDS assessment. Findings include: 12/17/16 through 12/23/16 - Review of the 7-day look-back period of R48's CNA documentation revealed that she had one incontinent episode of urine, which meant that she was occasionally incontinent of urine. 12/23/16 - The quarterly MDS assessment stated that R48 was frequently incontinent of urine. 3/7/17 at 9:10 AM - During an interview, findings were reviewed and confirmed with E4 (RNAC). 3/7/17 at 10:18 AM - Findings were reviewed with E2 (DON). The facility failed to accurately reflect R48's urinary incontinence status on the 12/23/16 quarterly MDS assessment.	F 278	1. R48 no longer resides at facility. If she returns, she will be re-assessed. Her latest MDS was reviewed and found to be correct. 2. RNACs will review and compare most recent MDS section H0300 to make sure it matches the 7 day look-back for each resident. Resident found to have conflicting results may be affected. 3. Section H0300 is prepopulated in the MDS by CNA documentation. A repair ticket has been opened with the electronic record vendor identifying the incorrect coding response to H0300. While the ticket is open, upon completing each MDS, RNACs will compare the 7 day look-back against the assessment response to ensure that the response is correct. RNAC will make a note for Section H0300 that the answer is correct and has been visually reviewed by the RNAC. 4. A sampling of 3 newly submitted MDSs will be reviewed weekly by DON or	

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F 278	Continued From page 11	F 278	designee to check that responses to Section H0300 match 7 day look back data. DON or designee will continue to check a sampling of 3 newly submitted MDSs weekly until the electronic record vendor makes the necessary electronic corrections. QAPI team will informed of outcome of the reviews.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		4/21/17

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F 309	Continued From page 12 (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for 1 (R72) out of 24 Stage 2 sampled residents. The facility failed to follow physician orders for Milk of Magnesia (MOM) administration for R72. Subsequently R72 did not have a bm for 5 days. Findings include: Review of R72's clinical record revealed: R72 had physician orders, dated 9/8/16, for MOM 30 ml to be given after 6 shifts (2 days) of no bm, if no results within 8 hours repeat dose of MOM, and if no results within 8 hours, repeat MOM for a total of 3 doses (in 24 hours). Review of R72's bm's from 2/6/17 through 3/6/17 revealed that R72 had a medium bm on 2/17/17 on the evening shift and had the next one on 2/23/17 (6 days or 17 shifts) which was large. Despite R72 going from 2/18/17 to 2/22/17 without bm's, review of R72's February MAR revealed: - MOM given on 2/21/17 on night shift after 12 shifts without a bm, although the physician order was to give after 6 shifts without a bm and MOM	F 309	1. R72 is alert and oriented and takes herself to the bathroom and she has since had a BM. 2. Residents who exceed 6 shifts between BMs may be affected. 3. Bowel Protocol was reviewed by DON and electronic alerts in Point Click Care were changed to match the bowel protocol. All nursing staff will be in-serviced on the bowel protocol by the Staff Development Director or designee. 4. DON or designee will review a sampling of 3 BM alerts daily (if there are 3 per day) until 3 consecutive days are 100% compliant with the Bowel Protocol. Thereafter, DON or designee will check a sampling of 3 BM alerts per week until 3 consecutive weeks are found to be compliant. Finally DON or designee will check 3 BM alerts monthly until 3 consecutive months are found to be compliant. Results of the monitoring will be reported to the QAPI team.	

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F 309	Continued From page 13 was not effective; - MOM given on 2/22/17 on evening shift and was not effective; - MOM given on 2/23/17 on day shift and was effective after 17 shifts without a bm. Findings were reviewed and confirmed by E2 (DON) during an interview on 3/7/17 at 10:20 AM. The facility failed to implement MOM when R72 went for 6 shifts without a bm and they failed to give MOM when there were no results in 8 hours and to repeat MOM every 8 hours up to 3 times in 24 hours until effective. Instead, the facility administered MOM daily for 3 days until R72 had a bm.	F 309		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 315		4/21/17

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F 315	Continued From page 14 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, review of other facility documentation as indicated and interviews, it was determined that for 2 (R41 and R48) out of 24 Stage 2 sampled residents, the facility failed to ensure that residents who were incontinent of bladder received appropriate treatment and services to restore continence to the extent possible. For R41, the facility failed to comprehensively reassess when the resident declined from frequently incontinent of bladder in October 2016 to always incontinent of bladder in December 2016; a 3 day voiding diary was not initiated to evaluate R41's bladder continence patterns so as to determine an individualized toileting program. For R48, the facility failed to comprehensively assess R48's urinary incontinence, including performing a 3-day voiding diary upon admission to the facility and following the 12/23/16 quarterly MDS assessment when it showed that her urinary incontinence increased; failed to individualize a toileting	F 315	1.1 R41 will have a new voiding diary followed by an individualized toileting schedule. 1.2 All residents who are incontinent have the potential to be affected. RNACs or designee will review the records of all residents at risk for incontinence to ensure that a voiding diary has been completed. 1.3 Incontinence Management Procedure will be revised to include initiating a new voiding diary if the resident assessment indicates a decline in incontinence in MDS section H0300. Staff development director or designee will in-service RNACs on changes to the Incontinence Management Procedure. (attachment #4) 1.4 A sampling of 3 MDSs will be reviewed by DON or designee weekly to ensure that the new procedural changes are followed until 3 consecutive weeks are	

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F 315	Continued From page 15 schedule based on the 3-day voiding diary; and failed to accurately reflect R48's urinary incontinence on the 12/23/16 quarterly MDS assessment. Findings include: Review of the facility procedure, last revised on 9/10/16 and entitled Incontinence Assessment/ Management stated, "... Upon admission and at least quarterly complete the Continence Evaluation... to determine continence/incontinence...if a resident is incontinent, complete a voiding diary upon admission or as needed in (facility EMR) for at least 3 days to assess for an individualized toileting schedule...". 1. Review of R41's clinical record revealed: R41 was admitted to the facility in March 2015 with diagnoses including stroke with left sided paralysis. R41 had a toileting plan implemented on 4/19/16 to offer and/or take resident to bathroom on or around toileting schedule at 1:30 AM, 3:30 AM, 5:30 AM, 8:30 AM, 11 AM, 1 PM, 5:30 PM, 8:15 PM, and 10 PM. Review of quarterly MDS assessments revealed that R41 was coded as frequently incontinent of bladder on 6/30/16 and 9/28/16. An admission (readmission after being in hospital), dated 10/17/16, also coded R41 as frequently incontinent of bladder, able to make reasonable and consistent decisions and required 2 person extensive assistance with transfers and toilet use. A Continence Evaluation, dated 10/18/16, stated that R41 had to rush to the bathroom when she felt the urge to urinate, leaks urine on the way to	F 315	found to be compliant. Thereafter, a sampling of 3 MDS will be checked monthly until 3 consecutive months are found to be compliant, at which time the monitoring will be concluded. Results of the review will be reported to the QAPI team. 2.1 R48 no longer resides at facility, but will be reassessed upon return. 2.2 All residents who are incontinent have the potential to be affected. RNACs or designee will review the records of all residents at risk for incontinence to ensure that a voiding diary has been completed. 2.3 Incontinence Management Procedure will be revised to include initiating a new voiding diary if the resident assessment indicates a decline in incontinence in MDS section H0300. Staff development director or designee will in-service RNACs on changes to the Incontinence Management Procedure. (attachment #4) 2.4 A sampling of 3 MDSs will be reviewed by DON or designee weekly to ensure that the new procedural changes are followed until 3 consecutive weeks are found to be compliant. Thereafter, a sampling of 3 MDS will be checked monthly until 3 consecutive months are found to be compliant, at which time the monitoring will be concluded. Results of the review will be reported to the QAPI team.	

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F 315	Continued From page 16	F 315		

the bathroom and can only hold urine less than 5 minutes from the time she had the urge to urinate. It was also noted that R41 takes a fluid pill that increases urination.

Review of the quarterly MDS assessment, dated 12/29/16, coded R41 as always incontinent of bladder, able to make reasonable and consistent decisions and required 2 person extensive assistance with transfers and toilet use.

Although R41 experienced a decline in urinary continence from frequently to always incontinent of bladder on 12/29/16, the facility failed to comprehensively reassess R41's continence status which included initiating a 3 day voiding diary to determine if the resident's toileting plan needed to be adjusted.

R41 was interviewed on 3/1/17 at 2:20 PM. R41 was alert, oriented to person, place and time and she was able to communicate clearly. R41 denied having a toileting schedule and stated that she uses her call bell to alert staff when she needs to use the bathroom. R41 stated a stand up lift was used to get her to the bathroom which required 2 CNA's. R41 confirmed that she was unable to hold her bladder for more than a few minutes after she gets the urge to urinate.

E17 (CNA) was interviewed on 3/7/17 at 11:55 AM as the CNA assigned to R41 was not available. E17 stated that she was familiar with R41. When asked about R41's toileting plan, E17 stated that R41 uses the call bell to let staff know "when she has to go" and that she needs a stand up lift to get to the bathroom.

E18 (CNA) was interviewed on 3/7/17 at 12:05

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F 315	Continued From page 17 PM. E18 stated that she had assisted with R41, the resident used her call bell to let staff know when she needed to use the bathroom and she was unsure if R41 was on a toileting schedule. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 3/7/17 at approximately 1:10 PM. During the exit conference E2 confirmed that R41 should have had another 3 day voiding diary completed after the decline in urinary status in December 2016. 2. Review of R48's clinical record revealed: R48 was admitted to the facility on 9/16/16 with diagnoses that included dementia, blindness and hearing loss. 9/17/16 at 1:01 AM - The admission Continence Evaluation stated that R48 was continent of bladder. However, the Evaluation also stated that R48 had bladder incontinence of less than 6 months, had more than 1 accident a day, urine leakage was contained, was aware of the urge to void and when wet and used incontinence products for containment. The Evaluation stated that R48 had a history of UTIs, transferred independently, occasionally asked for assistance, motivated to be continent and treatment options included use of incontinence products. The Evaluation lacked initiation of a voiding diary and identification of R48's type of urinary incontinence. The facility failed to comprehensively assess R48's urinary incontinence, which included initiation of a 3-day voiding diary. 9/25/16 - The admission MDS assessment stated that R48 was severely cognitively impaired, independent for toilet use and always continent of	F 315		

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F 315	Continued From page 18 urine. Review of the 7-day look back period revealed that R48 was continent of urine. Although R48 was continent of urine during the 7-day look back period for the MDS, the facility failed to comprehensively assess R48's continence status, which included initiation of a 3-day voiding diary, based on R48's 9/17/16 Continence Evaluation and care plan. Review of CNA documentation of R48's urinary incontinence revealed the following: - 9/16/16 through 9/30/16 - 4 incontinent episodes, 32 continent episodes and 10 refusals; - October 2016 - 13 incontinent episodes, 65 continent episodes and 5 refusals; - November 2016 - 11 incontinent episodes, 63 continent episodes and 11 refusals. 11/9/16 - R48 was care planned for behavior of self transferring and taking herself to the bathroom where she removed her attends (incontinence product) if it was wet or soiled due to confusion related to dementia. On 12/29/16, the facility initiated an care plan approach that included to check for placement of attends every shift. 12/16/16 at 8:01 AM - A Bowel and Bladder Program Screen stated that R48 did not void appropriately without incontinence at least daily, required assistance of 1 staff person to get to the bathroom/transfer/adjust clothing and wipe, was confused which required prompting and R48 was usually aware of the need to toilet. Based on the Screen, it stated that R48 was a candidate for scheduled toileting. 12/16/16 at 2:03 PM - The quarterly Continence Evaluation stated that R48 was incontinent of	F 315		

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F 315	Continued From page 19	F 315		

bladder, had no urinary accidents, urine leakage was contained, aware of the urge to void and when wet and used incontinence products for containment. The Evaluation also stated that R48 had a history of UTIs, transferred independently, occasionally asked for assistance, motivated to be continent, had mixed type of incontinence and treatment options included use of incontinence products. The Evaluation lacked initiation of a 3-day voiding diary.

12/16/16 - R48 was care planned for bladder incontinence with approaches including: toileting schedule, clean peri-area with each incontinence episode, monitor/document for signs/symptoms of UTI and encourage fluids during the day. It was unclear how the facility individualized R48's toileting schedule without initiation of a 3-day voiding diary to determine if she had a pattern of voiding.

12/16/16 - Review of the CNA Tasks revealed that R48 was placed on the following toileting schedule: 1 AM, 5 AM, 7:30 AM, 9 AM, 11:30 AM, 1 PM, 3:30 PM, 5 PM, 7:30 PM, 9 PM and 11 PM.

12/23/16 - The quarterly MDS assessment stated that R48 was severely cognitively impaired, required assistance of 1 staff person for toilet use, currently on a toileting program and frequently incontinent of urine. Review of the 7-day look back period for this assessment revealed only 1 episode of incontinence, which meant that R48 was occasionally incontinent of urine. The MDS assessment failed to accurately reflect R48's urinary incontinence.

Review of CNA documentation of R48's urinary incontinence revealed the following:

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F 315	Continued From page 20 - December 2016 - 16 incontinent episodes, 56 continent episodes and 11 refusals; - January 2016 - 18 incontinent episodes, 62 continent episodes and 2 refusals; - February 2016 - 8 incontinent episodes, 60 continent episodes and 2 refusals. 3/7/17 at 9:10 AM - During an interview, E4 (RNAC) reviewed and confirmed the findings. 3/7/17 at 10:18 AM - Findings were reviewed and confirmed with E2 (DON). The facility failed to ensure that R48, a resident who was incontinent of urine, received treatment and services to restore continence to the extent possible by the: - failure to comprehensively assess her urinary incontinence, including initiation of a 3-day voiding diary, upon admission to the facility and following the 12/23/16 quarterly MDS assessment when it showed that her urinary incontinence increased; - failure to individualize a toileting schedule based on the 3-day voiding diary; and - failure to accurately reflect R48's urinary incontinence on the 12/23/16 quarterly MDS assessment.	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		4/21/17

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F 323	Continued From page 21 (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, interviews and review of facility records, it was determined that for one (R73) out of 24 Stage 2 sampled residents, the facility failed to ensure that each resident received adequate supervision and the resident environment remained as free from accident hazards, as was possible. The facility failed to ensure that R73, who was a high risk for falls and at risk for wandering, was supervised to ensure safety. Additionally, Lysol wipes were observed in a resident area which had cognitively impaired residents ambulating in the area. Findings include: 1. Review of R73's clinical record revealed: R73 was originally admitted to the facility on 7/24/13 with diagnoses that included dementia. Review of the EMR and facility documents	F 323	1.1. R73 was not injured. 1.2. All residents who attend the safety program have the potential to be affected. RNACs or designee will review care plans for all residents attending the safety program to ensure their care plans for wandering and fall potential are up to date and reflect residents current condition. 1.3. Safety Program Procedure (attachment #5) will be created to monitor the entrance and exit of each resident for the program. This record will be reviewed daily by Nursing Supervisor to make sure the schedule is followed. 1.4. DON or designee will review attendance record and visually check that residents scheduled to be in the program are present daily for 3 days until 3 consecutive days are found to be compliant. Thereafter, DON or designee will review attendance and visually check	

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F 323	Continued From page 22 revealed the following: 12/18/13 - The facility initiated a care plan, last revised 7/26/16, for the problem "...is an elopement risk..." included the interventions to "assess for fall risk, check wanderguard placement every shift," and "distract resident from wandering by offering pleasant diversions, structured activities/food/conversation, television, book...". 4/21/14 - The facility developed a care plan, last revised 2/20/17, for the problem "...had a fall...". On 10/3/16 the facility initiated the intervention, "Resident to attend safety program after breakfast 7AM - 4PM." 10/14/16 - A quarterly MDS assessment stated that R73's daily decision making skills were severely impaired (never/rarely made decisions), that R73 required supervision of one staff person for walking in her room and in the corridor, and that R73 had a history of falls. 10/26/16 - A Morse Fall Scale is completed identifying R73 as being at high risk for falling. 11/2/16 timed 2:55 PM - A progress note states, "A charge nurse found resident on the 1st floor stairwell walking down the lower end of the stair well. Per the charge nurse, resident's hand were (sic) on the hand rail and resident was ambulating without difficulty. Resident was directed to the elevator and escorted back to the floor. Resident alert x 1 with confusion. No injuries noted upon assessment...Staff placed on the stairwell entrances until the magnetic locks were fixed...". 11/2/16 - The electronic Documentation Survey	F 323	that residents scheduled to be in the program are present weekly until 3 consecutive weeks are found to be compliant. Result of the monitoring will be reported to QAPI. 2.1 No residents were affected. 2.2 All residents who are confused may be affected. 2.3 Lysol Disinfecting wipes were removed from the hallway during the survey. All Nursing staff will be in-serviced to be reminded that Lysol Wipes must be secured when to being used. All Lysol Wipes will be collected and secured in the Medication cart so access will be controlled by Charge Nurse. 2.4 Environmental Services Director will spot check daily for unsecured Lysol Wipe containers until 3 consecutive days are found to be free from unattended Lysol Wipes. Thereafter, ESD will spot check weekly for unsecured Lysol Wipes until 3 consecutive weeks are found to be compliant. Results of the spot check will be reported to QAPI team.	

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F 323	Continued From page 23 Report, completed by CNAs, was signed off at 2:59 PM signifying that R73 attended the safety program from after breakfast until 4 PM. 11/11/16 - The facility's incident report stated under "Summary:...Per nurse (name) statement who found resident, 'Approximately 11:30 AM, returning from his break...I entered the 1st floor stairwell and observed (R73) walking down the lower end of the stairwell...I assisted the resident and redirected her back to the 2nd floor via the elevator...". 3/2/17 1020 AM -Observed R73 arriving on the 4th floor with a CNA. R73 was ambulating while holding the CNA's hand. 3/2/17 approximately 1:30 PM - During an interview with E10 (DMM) he stated that on 11/2/16 the facility held a fire drill and provided a report. The Fire Alarm Checklist revealed the fire drill started at 11 AM and ended at 11:30 AM. 3/6/17 8:40 AM - R73 was observed in the 2nd floor dining room eating breakfast and with a wander guard bracelet applied to her right ankle. 3/6/17 8:55 AM - During an interview with E19 (Nursing Supervisor), she was asked what the "safety program after breakfast until 4 PM" was? E19 stated that it is when a resident is taken to the 4th floor program for supervision. 3/6/17 10:38 AM - An interview was conducted with E2 (DON) regarding the 11/2/16 incident when R73 was found in the stairwell. Findings were reviewed with E2 that according to the care plan R73 was to have been in the safety program on the 4th floor from after breakfast till 4 PM and	F 323		

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	085047	A. BUILDING _____ B. WING _____	03/07/2017

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F 323	Continued From page 24 that CNA documentation states she attended the program. The facility failed to ensure that R73, who was a high risk for falls and at risk for wandering, had care plan interventions followed to ensure adequate supervision and safety. R73 had a care plan intervention initiated on 10/3/16, to attend the safety program after breakfast till 4 PM. On 11/2/16 a fire drill occurred at approximately 11 AM. CNA documentation revealed R73 attended the safety program after breakfast. It is unclear how R73 ended up in the stairwell between the 1st and 2nd floors walking down the stairs. The facility failed to ensure R73's supervision and safety as per the plan of care. 3/7/17 approximately 1 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2. 2. On 2/17/17 at approximately 8:35 AM, a surveyor observed a container with Lysol wipes, a disinfectant, left unattended on the second floor Gilpin Hallway table. On 2/17/17 at approximately 9:00 AM, the surveyor observed the container of Lysol wipes still left unattended. The Material Safety Data Sheet for Lysol Disinfecting Wipes, dated 2/29/12, stated that the wipes may cause eye irritation as a potential short term health effect. Findings were reviewed with E10 (DMM) and E11(DES) on 3/1/17 at approximately 11:45 AM. Findings were reviewed with E1 (NHA) and E2	F 323		

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F 323	Continued From page 25 (DON) on 3/7/17 at approximately 1:15 PM.	F 323		
F 333 SS=E	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it was determined that the facility failed to ensure that one (R64) out of 24 Stage 2 sampled residents was free of significant medication errors. Observation during a medication pass revealed that the facility failed to administer R64's insulin as ordered. Additionally, review of R64's EMR revealed approximately 20 occasions when the facility failed to administer Humalog or Novolog insulin before meals and/or failed to administer the correct insulin sliding scale coverage (dosage). Findings include: Observation and review of R64's clinical record and EMR revealed the following: 3/1/17 8:35 AM - Observed E6 (LPN) pour a total of nine (9) medications (tablet form) and administered them to R64. During the surveyors' medication reconciliation it was noted there was a physician's order (renewed 2/11/17) for R64 to receive Novolog 6 Units before each meal and a second physician's order (renewed 2/11/17) for Novolog sliding scale coverage to be given based on fingerstick results (blood sugar level). Review	F 333	1. R64 was not injured and her orders were clarified by the physician during the survey. 2. All residents receiving insulin will have their insulin orders reviewed by the DON or designee. 3. Staff Development Director or designee will provide in-service to all nurses regarding proper administration of insulin, followed by medication administration test. 4. Staff Development coordinator or designee will conduct a sampling of 3 Med Pass competencies weekly until 3 consecutive weeks are found to be compliant. Thereafter Staff Development Director will conduct a sampling of 3 Med Pass Competencies Monthly until 3 consecutive months are found to be compliant. Results of the samplings will be reported to the QAPI team.	4/21/17

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F 333	Continued From page 26 of the eMAR, dated 3/1/17 and timed 8 AM, revealed that R64's fingerstick was equal to 143. The Novolog sliding scale coverage orders stated that there was no coverage if the blood sugar level was 150 or less. Further review of the 3/1/17 eMAR revealed that although the 8 AM Novolog 6 Units before breakfast was initialed by E6 (usually signifies medication was given), the clinical findings notes at the back of the eMAR stated that it was "not given." 3/1/17 at approximately 10 AM - R64, who is cognitively intact, was interviewed while in the therapy department and asked if had she received any insulin this morning? R64 stated that she had not received any insulin this morning and that "sometimes I get it, sometimes I don't." R64 also stated that she had forgotten to ask the nurse what her blood sugar level was this morning. 3/1/17 10:20 AM - E6 was interviewed and stated that R64's blood sugar was 143, so she didn't need any sliding scale coverage this morning. E6 stated "If finger stick less than 150 then no coverage." E6 was then asked if she had given the Novolog 6 Units before breakfast? E6 confirmed she did not give R64 any insulin this AM. The facility failed to administer R64's Novolog 6 Units before breakfast on 3/1/17 at 8 AM as ordered by the physician. Review of the EMR revealed the following: 12/21/16 - A physician's order stated for R64 to receive Humalog 6 Units three times a day at 8 AM, 11:30 AM, 4:30 PM.	F 333		

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F 333	Continued From page 27 Review of the 1/17 eMAR revealed that although initialed, clinical findings notes stated that Humalog 6 Units was "not given" on the following dates and times: 1/3/17 12 PM - Humalog 6 units documented not given; 1/4/17 5 PM - Humalog 6 units documented not given; 1/5/17 12 PM - Humalog 6 units documented not given; 1/6/17 8 AM - Humalog 6 units documented not given. 2/11/17 - A physician's order stated for R64 to receive Novolog 6 Units three times a day at 8 AM, 11:30 AM, 4:30 PM. Additionally, a second physicians order stated Novolog sliding scale coverage based on blood sugar level before meals and at bedtime. The sliding scale orders stated, "less than 150 - no insulin; 151-200 - 1 Unit; 201-250 - 2 Units; 251-300 - 3 Units; 301-350 - 4 units; greater than 350 - 5 Units." Review of the 2/17 eMAR revealed that although initialed, clinical findings notes stated that Humalog 6 Units was "not given" on the following dates and times and/or the incorrect sliding scale coverage was given: 2/12/17 8 AM - Novolog 6 units documented not given; 2/12/17 5 PM - Novolog 6 units documented not given; finger stick equaled 157, and R64 should have received an additional one (1) unit coverage, however nurse's initials were crossed off signifying it was not given and there were no additional notes; 2/13/17 8 AM - Novolog 6 units documented not given;	F 333		

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F 333	Continued From page 28 2/14/17 12 PM - Novolog 6 units documented not given; 2/15/17 8 AM - Novolog 6 units documented not given; 2/17/17 12 PM - finger stick equaled 278 and should have received 3 units Novolog sliding scale coverage, however only two (2) units were signed off as given; 2/18/17 5 PM - no finger stick results documented; nurse's initials for the Novolog 6 Units and sliding scale coverage crossed out signifying not given, but no notes with explanation; 2/18/17 9 PM - finger stick equaled 188 and should have had one (1) unit Novolog sliding scale coverage, but nurse's initials are crossed out signifying it was not given; 2/19/17 5 PM - no finger stick results documented; nurse's initials for the Novolog 6 Units and sliding scale coverage crossed out signifying it was not given; 2/21/17 8 AM - Novolog 6 units documented not given; 2/22/17 5 PM - Novolog 6 units documented not given; 2/23/17 8 AM - Novolog 6 units documented not given; 2/25/17 8 AM - Novolog 6 units documented not given; 2/26/17 12 PM - Novolog 6 units documented not given; 2/27/17 8 AM - Novolog 6 units documented not given; 3/1/17 8 AM - Novolog 6 units documented not given. The facility failed to ensure that R64 was free of significant medication errors.	F 333		

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F 333	Continued From page 29 On 3/2/17 at approximately 3:30 PM findings were reviewed with E2 (DON). E2 confirmed that one would expect that when a medication is not given the nurse's initials would be crossed off on the eMAR. E2 stated she would call their pharmacy provider for information. At approximately 5 PM, E2 returned and stated that she had spoken with their pharmacy regarding the documentation. E2 stated that according to the pharmacy, the nurse's initials acknowledge that the task was done, however, notes on the back of the eMAR state whether the medication was given or not given. E2 confirmed that based on the eMAR notes, multiple doses were documented as not given and/or incorrect sliding scale coverage was given. 3/7/17 approximately 1 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference.	F 333		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		4/21/17

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F 441	Continued From page 30 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective	F 441		

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F 441	Continued From page 31 actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain an infection control program to prevent the spread of infection and communicable diseases on 2/27/17 during the lunch observation in the 2nd floor dining room when a staff member was observed picking up bm from the floor with a paper towel and then walked away to discard the bm and the floor was not sanitized or disinfected where the bm made contact. Findings include: On 2/27/17 at 12:10 PM during the 2nd floor dining observation of lunch on the independent side, a formed bm approximately 2-3 inches in length was observed on the floor. There were residents seated in the dinning room as well as some residents still entering the dining room. Dining room staff were serving drinks and food. Within a minute of the surveyor observing the bm, E16 (staff development) picked the bm up with a paper towel and then left the dining room to discard the bm. The area of the floor where the bm made contact was not covered with a paper towel or anything to mark the spot so the area could be sanitized or disinfected and to prevent anyone from stepping in the contaminated area.	F 441	1. No evidence of BM was found on the floor and floor was sanitized immediately after the meal as it is after every meal. 2. All residents who attended the meal in the 2nd floor dining room have the potential to be affected, however there is no evidence any residents were affected. 3. Spill kits will be provided to each unit. Staff Development director or designee will in-service all nursing staff on the proper use of the spill kit for containing body fluids. DON or designee will conduct Safety Competency (attachment #1) regarding body fluids. 4. DON or designee will conduct 3 Safety Competencies daily (attached #1) to ensure staff's understanding of this procedure since these occurrences are rare. Once 3 consecutive days are found to be compliant, DON will conduct 3 competencies weekly until 3 weeks are found to be 100% complaint. Results of the competencies will be reported to QAPI team.	

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F 441	Continued From page 32 Findings were discussed with E16 and E2 (DON) on 2/27/17 at 1415. E16 stated, "At first I didn't realize what I was picking up and after I realized it was bm, all I could think was to get it (bm) out of there and not throw it in a trash can." E2 stated she would have the entire dining room floor sanitized immediately.	F 441		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: March 7, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual recertification survey was conducted at this facility from February 27, 2017 through March 7, 2017. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 105. The Stage 2 survey sample size was 24.		
3201	**Regulations for Skilled and Intermediate Care Facilities** **Scope**		
3201.1.0 3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**		
	This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed March 7, 2017: F164, F223, F241, F253, F278, F309, F315, F323, F333, F441.	Cross Refer to the CMS 2567-L survey completed March 7, 2017: F164, F223, F241, F253, F278, F309, F315, F323, F333, F441.	4/21/17

Provider's Signature _____ Title Administrator Date 3/29/17